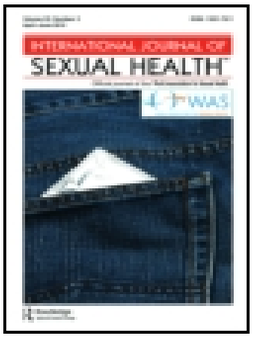

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An exploration of the perspectives and experiences of General Practitioners in Barbados in relation to Lesbian, Gay, Bisexual and Transgender (LGBT) Patients

Brief Report Submission

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Lesbian, gay, bisexual and transgender (LGBT) people experience many of the same health issues as the general population, but they also face specific health risks and healthcare disparities, many of which are linked to social stigma. These include increased risk of specific sexually transmitted infections (STIs), hormone treatment and surgery needs for transgender persons (Lee, 2000), increased breast and ovarian cancer risk in lesbians (Mravcak, 2006); and increased mental health risk and substance misuse among LGBT persons, generally (Lee, 2000). Being denied and avoiding routine healthcare is an important contributing factor to these health risks (Institute of Medicine, 2011) and can occur because practitioners are perceived, or encountered, as insensitive, or as having negative attitudes towards sexual minorities (Westerstahl & Bjorkelund, 2003). Barbados criminalizes homosexuality with anti–sodomy laws dating back to the colonial era, and calls for decriminalization have faced religious opposition (Maiorana & Rebchook, 2013). Despite rare enforcement, some argue that the mere existence of these laws "strengthen social stigma" (International Lesbian and Gay Association, 2008, para.4) and violates international human rights law (International Lesbian and Gay Association, 2008; Maiorana & Rebchook, 2013). Physicians play a normative societal role and can directly influence quality of care (Matthews, Booth, Turner, & Kessle, 1986), but studies in the US and UK suggest that some doctors are uncomfortable with taking sexual- and sexual-orientation histories (Hinchliff, Gott, & Galena, 2004; Stein & Bonuck, 2001). Guidelines from several English-speaking countries consistently recommend that primary care practitioners strive for inclusive, confidential, culturally competent and knowledgeable care that can also address the specific health needs of LGBT patients (McNair & Hegarty, 2010). In the Caribbean, little research has examined how the local milieu affects health access and utilization by LGBT

people, with most of the regional literature focusing on men who have sex with men (MSM) in the context of HIV (Advocates for Youth, 2010). However, a study from the Netherlands Antilles showed that most gay men and lesbians were not asked about their sexual orientation by doctors, and would not disclose this if the doctor was perceived as homophobic (Radix, Buncamper, &Van Osch, 2004).

Methods

Between June and July 2013, qualitative, semi-structured interviews were conducted with Medical Council registered GPs (non-specialized or Family Medicine-specialized) in St. Michael and Christ Church, Barbados. GPs with other specialties or practicing solely at the Queen Elizabeth Hospital (QEH) were excluded and recruitment was limited to a maximum of 12 participants due to limited time and resources available. Participants were selected purposively to reflect diversity in gender, age, years of professional experience, and practice in both public and private sectors. This sampling approach seeks to capture the range of GPs' experiences and perspectives rather than statistical representativeness of the GP population. In the results section, we describe the characteristics of the sample as a whole but provide no further breakdown so as to protect participant anonymity. Half of the participants were selected from either a list provided by local polyclinics (public-sector GPs) or the local telephone directory (private-sector GPs). The other half was recruited via snowball sampling utilizing the researcher's existing professional network, taking care to avoid close colleagues and analyzing resulting data with appropriate reflexivity. Interviews took place at participants' offices during working hours and employed a topic guide informed by both a literature review of best practices and of LGBT patient concerns. The topic guide covered: history taking/discussions on sexual health and sexual

orientation/gender identity; screening recommendations for LGBT patients; confidentiality procedures; and training on LGBT health. Main questions were either open-ended, or closed-ended with follow-up probes as appropriate, for example "Are there any specific health issues you discuss with a gay male patient?" which was then probed by asking about screening recommendations for this group of patients. Whilst all participants were asked whether they made specific screening recommendations for their LGBT patients, especially with regards to mental health, they were not asked to address an itemized list of these recommendations. Data on facilitators and barriers were generated both directly - asking contrasting opening questions, such as "What makes it easier to discuss sexual orientation with your patients?" followed by "What makes it more difficult to discuss this?" – and indirectly, where participants raised these issues without specific prompting. Interviews were audio-taped and transcribed verbatim. Thematic analysis was then utilized, which identified and analyzed the patterns, or themes (Braun & Clarke, 2006), emerging both directly from the data and based on a prior literature review. This analysis involved ascribing 'codes' to each segment of text, which were then compared within and between interviews, to eventually be collated and collapsed into themes. Coding and analysis was conducted by one researcher, who inputted the data into a spreadsheet software (Microsoft Excel), for easier manipulation and visualization of the coded texts. This study was approved by the London School of Hygiene and Tropical Medicine (LSHTM) Ethics Committee and the University of the West Indies (UWI)/Barbados Ministry of Health Institutional Review Board. Participants were given study information sheets and written consent obtained prior to beginning interviews. Interviews were conducted in private rooms and

transcripts were anonymized with random pseudonyms. No master list linked participant name to assigned pseudonym.

Results

Of the twelve GPs contacted, ten agreed to participate in interviews averaging 22 minutes. Equal numbers of men and women participated, aged between twenty-seven to over fifty-five, six practicing publicly and four privately, with between four and twenty years of experience as a GP. Four participants had either completed, or were currently enrolled in post-graduate training in Family Medicine. Two participants reported never having provided care for an LGBT patient in Barbados, in spite of over 5 years of practice, and four others had only encountered one or two LGBT patients. Analysis identified three key themes: scant discussions on sexual health, practices and identity; varied understandings of sexual and gender identity; and invisibility of LGBT patients and their specific health care needs.

Scant Discussions on Sexual Health, Practices and Identity

Just three participants routinely took sexual histories. Others utilized complaint-based guidance or only routinely asked reproductive-age patients, especially women. Most sexual health discussions were doctor-initiated, based either on gynecological history or perceived patient "promiscuity" (Betty) gauged from patients' dress and behavior. Almost half the participants had discussed sexual practices with gay or lesbian patients. In some cases, this information was volunteered by patients themselves, but in others, it was derived from doctors' questions, some participants stressing that their inquiries were no different during consultations with LGBT or heterosexual patients. An exception was a GP who specifically asked lesbian

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patients about sexual practices: “This might be a little bit biased - but I tend to do it [take a sexual history] for lesbians a bit more because of the myths that pervade lesbianism that you don't get STIs, so I tend to go a little bit more into their business in that group” (Harold). Discussion of sexual health and practices appeared to be facilitated by factors at the level of the patient, such as open personality; the doctor, such as comfort with the topic, non-judgmental attitudes, a special interest in sexual health, and a holistic medical approach; the patient-doctor relationship, such as comfort, rapport, trust, longer medical practice careers and an established relationship; and the environment, such as a dedicated sexual health clinic. Challenges to discussing sexual health and sexual practices included topic sensitivity and limited consultation timing, for both routine and acute visits. Some GPs considered male patients to be more reticent to these discussions. Age, meanwhile, was identified both as a challenge and a facilitator; some GPs considered younger patients to be especially uncomfortable with sexual health-related discussions, while others felt they took the initiative in these discussions.

All public-sector GPs, and one in the private sector, felt that patient notes lacked confidentiality, and weighed the need to remember LGBT patients’ sexual or gender identity against possible stigmatization by other health staff intercepting the notes during routine handling. One GP said about his LGBT patients “I don’t want them to be biased by the other people that have access to the notes. So while I’m not concerned about doctor to doctor, I am concerned about doctor to records clerk especially…and a lesser extent doctor to nurse” (Timothy). Most participants thus made mental notes, only recording this information if it was especially relevant to continuity of care, or in one GP’s case, used coded notations. All participants stated that they would only discuss sexual orientation with relatives if requested to

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do so by the patient, but some might discuss it with colleagues to garner a second opinion on health care course, often anonymizing the information or asking patient consent in advance. A few participants highlighted the tendency of healthcare staff to gossip amongst themselves, and one noted that nurses often asked the GPs curious questions when seeing an LGBT patient: “Sometimes nurses would come in and say 'That boy did look very strange' trying to elicit a response, or find out what the boy came for. I don't entertain that sort of stuff” (Harold).

Varied Understandings on Sexual and Gender Identity

Only one participant routinely asked patients about their sexual orientation. The others established this information either by asking patients based on an assessment of their mannerisms, medical history and findings, or by the patient volunteering the information unprompted, as with the gay male patient who “made a joke – ‘I think my boyfriend might be ill too' and those kinds of comments. So if you didn't know or figured out he would've said; he didn't give you a chance to ask” (Patricia). Three participants mentioned that patients had disclosed their sexual orientation in response to the GP’s questions about heterosexual relationships: “You ask about the contacts, ‘How was the love life? Do you have a boyfriend or something?’ And they went, ‘No doc, I'm a lesbian, I don't like men’” (Samuel). Six participants defined the term transgender as “identifying as the opposite sex” (Andrew), with variations in the exact wording used, while the other four equated the term with cross-dressing, sexual orientation or confusion about sexual orientation. All but three of the participants had never had gender identity come up in consultations, and none discussed it routinely. For two of these participants, the discussion had arisen during their psychiatry rotations, and the other initiated a discussion because it was facilitated by the patient's appearance and openness to the discussion. Participants

who had met transgender patients tended to refer to them with pronouns reflecting their sex at birth rather than their gender identity.

Three participants referred to sexual orientation as a “preference,” using terms like “switching,” “shifting,” and referring to heterosexual relationships as “normal,” thus implying homosexual relationships to be abnormal. One participant, when describing health discussions with a gay male patient, said: “The guy seemed happy so I didn't try to explore what put him in that direction...why he believes he is homosexual, and what put him there.” (Timothy), later theorizing that his sexual orientation may have resulted from past trauma, either within heterosexual relationships or following abuse. Homosexuality here, then, was perceived in terms of psychopathology, but not necessarily as detrimental to current well-being. Many of the other participants, however, referred to their patients’ sexuality as an “orientation” and appeared to attach no pathology to it. One GP when asked whether she ever discussed sexual orientation with patients concisely stated “Usually it comes up if the person is comfortable and if I do ask I don't make a big deal of it, I just ask how many partners – men or women or both and that's it.” (Mary).

The Invisible LGBT Patient and their Specific Health Care Needs

The finding that more than half of participants lacked experience with LGBT patients, despite often extensive practice experience, suggests an invisibility of this population, further reinforced by a lack of LGBT-specific health recommendations and training. Almost all participants insisted that they treat, or would treat, LGBT patients “not that different from heterosexuals” (Andrew) during consultations. However, health discussions with all sub-groups

of this population focused mostly on STI screening and safe sex, where LGBT persons were treated homogeneously in sexual risk assessments. Many participants saw gay men as especially high-risk for acquisition and transmission of HIV and STIs, and almost half of participants focused on the risks of anal sex. As one GP said when asked about his health discussions with gay male patients, “Generally if they told me that they're homosexuals then I just pin it generally down to homosexual activities in terms of the risk involved of doing anal sex tends to be higher.” (John). Some thought that patients who identified as lesbians would often still have sex with men, so advice on contraception and STIs was offered. Few GPs could name any LGBT-specific screening recommendations beyond sexual health. Only two participants would consider screening LGBT patients for mental health issues (mentioning depression, anxiety and intimate partner violence), but they didn't usually do this in practice. The remaining participants either thought inquiries about mental health irrelevant or would only screen if indicated by patient complaint. A few participants mentioned transgender persons as particularly vulnerable to mental health issues, including suicide and stress due to mistreatment by others as a result of their gender identity. Most participants did not specifically screen for substance use in LGBT persons, though a few routinely did so for all patients.

LGBT Invisibility Began During Training

Younger participants received medical school sexual health training, but only in one case did this specifically address LGBT health. The post-graduate Family Medicine program offers a sexuality module which includes LGBT issues, but otherwise, opportunities for education on LGBT matters are limited. One participant summed this up as follows: “Med school – nothing.

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After med school... one evening talk on STIs, that's it, not on sexual stuff, just because they wanted some sort of protocol for STI treatments." (Timothy).

Every participant believed increased training on LGBT issues was needed, although one suggested training be confined to medical school and not with GPs. Training suggestions included incorporation of LGBT health into medical school curricula (though some noted the already crowded schedule); lectures; and workshops on LGBT health organized by the Medical Association, UWI or the Ministry of Health. Suggested format and content included didactic lectures utilizing statistical data on LGBT needs or case-histories; sit-in sessions with doctors more experienced in LGBT health; transgender-specific lectures; role-playing sessions where physicians practice interviewing LGBT patients; and personal narrations of healthcare experiences by LGBT people. Some suggested the Family Medicine module on sexuality be made available to all GPs.

Many suggested tying training to accreditation points for registration, thereby ensuring high participation, but various implementation challenges were identified. These included societal ones; for example, GPs' fear of religious opposition, and homophobia; professional ones, like disinterest in organizing training, lack of evidence and awareness of the need for training, and physician discomfort with sexuality; and methodological, like overcoming non-attendance (since GPs may be reluctant to forgo earnings to attend), training with a non-confrontational or non-dictatorial attitude, and factoring in GPs' cultural and personal background(s). Speaking about a recent training in adolescent sexuality, one GP noted: "It was like 'You should never tell anybody this, you should never that;' when you get that top-down

approach to training, people will switch off because they have their own personal beliefs." (Valerie).

Two participants anticipated no challenges to training since LGBT patients were encountered in every practice, thus all GPs should be eager to learn how best to serve this group.

Discussion

For most GPs participating in this study, discussions of sexual health, practices and orientation were typically complaint-based, similar to other settings (Hinchliff et al., 2004; Westerstahl & Bjorkelund, 2003), and gender identity was almost never discussed. Similar to GPs in the UK, consultation timing and context were major challenges to discussing sexual health, practices and identity (Gott, Galena, Hinchliff, & Elford, 2004). Health discussions with LGBT patients focused almost exclusively on safe sex and STIs, consistent with other studies (Boehmer, 2002), which is unsurprising given that medical discourse on LGBT health issues in the Caribbean centers on HIV, and globally doctors lack information on LGBT patients' broader health needs (Bjorkman & Malterud, 2009; Hinchliff et al., 2004; Rutherford, McIntyre, Daley, & Ross, 2012). Participants in this study showed limited awareness of LGBT patients' mental health and routine screening needs. Unlike findings from other settings (Scherzer, 2000; Seaver, Freund, Wright, Tjia, & Frayne, 2008), not all GPs in this study neglected STI screening for gay women, however this appeared to be grounded in the perception that they were likely to 'switch' to men rather than any real understanding of lesbian sexual practices. Patients sometimes voluntarily disclosed their sexual orientation, but confidentiality deficits in record keeping and

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among healthcare staff is a major concern, especially in the public sector, as has been documented elsewhere in the Caribbean region (Rutledge, Abell, Padmore, & McCann, 2009). The tendency for LGBT patients to be rendered 'invisible' by homogeneous health promotion and care is also reflected in the international literature (Makadon, 2011) and, although equal treatment of LGBT patients is well-intentioned, it risks culturally incompetent health care for this group. Medical school training on LGBT health was almost non-existent in participants' experience, and similar to other studies (Hinchliff et al., 2004; Rutherford et al., 2012), almost all participants articulated need for under- and post-graduate training in this area.

These findings have implications for policies and practice on GP health communication, training and confidentiality in Barbados. Recommendations, in line with Hinchliff et al. (2004), include communication training for GPs within a context of sexual and LGBT health issues, with the selected training format(s) being resource-driven. Medical school training in the US and UK has proven successful in improving knowledge and interactions with LGBT patients (Dixon-Woods et al., 2002; Kelley, Chou, Dibble, & Robertson, 2008). In Barbados, GP training on LGBT health will require governmental and/or medical professional leadership on implementation, and should be bolstered by research on LGBT people's health needs and barriers to accessing care.

Overcoming lack of time available for training (also experienced by GPs in the UK; Hinchliff et al., 2004) and personal prejudices will require careful planning and alliances with accreditation and professional educational bodies. Addressing confidentiality deficits will require long-term overhauling of government-directed medical record keeping, storage and health center protocols, along with shifts in cultural attitudes towards both confidentiality and LGBT patients.

GPs can assist by establishing explicit non-discriminatory and confidentiality policies and practices, to help destigmatize sexual minorities in healthcare settings. As White, Barnaby, Swaby, and Sandfort (2010) suggested, legislating non-discrimination and decriminalizing homosexuality can improve health professionals' attitudes, behaviors, and training approaches. Whilst this will require wider activism and structural reform, the medical profession can advocate for such change and, in its absence, model sensitive, culturally competent care for LGBT patients.

Several limitations to this study must be noted. For logistical reasons, only ten GPs were interviewed, in two parishes, and findings are thus not necessarily generalizable to all GPs in Barbados. However, the study population reflected a range of GP training, professional practice, public and private sectors, and demographic characteristics. Interviews were short, being conducted during working hours, and time and resource constraints precluded triangulation of findings with other methods. However, this study can inform further qualitative and quantitative research on GPs' and healthcare providers' interactions with LGBT patients, and LGBT patients' views and experiences of healthcare. The lack of extremely homophobic and transphobic attitudes, and the presence of some relatively LGBT-friendly perspectives, may be due in part to GPs with negative views not volunteering for interviews, as well as the use of snowball sampling. However, questions were non-leading and a non-judgmental approach encouraged participants to freely express their views, and similar attitude ranges were found in those purposively sampled without snowballing.

Conclusion

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Taking into account its limitations, this study suggests that LGBT patients and their health needs are largely invisible in Barbadian GP practices, and are treated by GPs with attitudes ranging from sensitivity to perceived abnormality. Diagnostic and screening recommendations skew towards sexual health, with low awareness of mental health and substance use issues. Recommendations for action involve improving GP communication on, and knowledge of, LGBT people's health needs by incorporating relevant training into medical school and GP lecture curricula, workshops or post-graduate specialization, in order to improve culturally competent LGBT healthcare. Societal and operational challenges to implementation will need to be accounted for, while major confidentiality deficits in record keeping and among healthcare staff must also be addressed.

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